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Original Articles.

ON CASES OF NIGHT-BLINDNESS WITH PECULIAR CONJUNCTIVAL CHANGES IN CHILDREN.*

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At a meeting of the Section held on May the 26th last I exhibited a little boy, aged 5 years, who was brought by his mother to the Queen's Hospital for Children because he could not see at night and had "white spots" on his eyes. Examination of the blood showed that hæmoglobin was 68 per cent., red cells were 3,900,000, and white cells 8000 per c.cm. The colour-index, then, was 0·87.

The interest excited by the foregoing case led me to believe that a brief description of this curious condition, which does not seem to be at all generally recognised outside the ranks of ophthalmic surgeons, might not be wholly devoid of interest to members of the Section. Yet it is not altogether uncommon in the neighbourhood of London, provided one knows where to look for it, and looks for it at the right season. It prevails in children belonging to the lower strata of society, as, for example, such as are to be found as inmates of poor-law schools, orphanages, and so forth. In order to give my hearers some idea of its prevalence in those places, I may say that I found it to be present in 1·87 per cent. of 6209 presumably healthy

* A communication read before the Section for the Study of Disease in Children of the Royal Society of Medicine on October the 27th, 1911.

children whose eyes I examined a few years ago. On the other hand, in my experience it is not at all common in children's hospital work, mainly, I suppose, because the affected children seldom make any complaint of their eyes, and also because the hospital class, as a class, is notoriously unobservant. At the same time, a few cases have been reported from the London Hospital by Stephen Mayou (2) and by Malcolm L. Hepburn (2) respectively. Speaking for myself, I have seen occasional cases in the ophthalmic department of the Queen's and the Evelina Hospitals for Children. But I have yet to meet with a case among children of the better class, *i. e.* such as would consult us in private practice.

It prevails in summer and autumn, and is seldom seen during the winter months.

The symptom-complex, in its fully developed form, includes—first, changes in the ocular conjunctiva, and secondly, night-blindness. This conjunction is sometimes spoken of as "Bitot's syndrome," despite the fact that it was described (4), though perhaps not very fully, by de Hubbenet, a Russian army surgeon, in 1860, that is, three years before Bitot wrote (5).

The conjunctival changes are seldom seen except in that part of the ocular conjunctiva which is exposed when the lids are open, the so-called "interpalpebral zone" (E. Fuchs). They usually affect both eyes, sometimes to an unequal extent. They occur as more or less triangular areas (often situated one on each side of the cornea), which are dry, and look as if they had been bespattered with tiny particles of white foam. If the foam-like material be wiped away (a simple affair), it is reproduced within twenty-four to thirty-six hours after complete removal. The glistening, dry-looking plaques, if once seen, can scarcely be mistaken for anything else. To the condition the name "epithelial xerosis" (Saemisch) is commonly applied.

In my experience, and in that of every other observer who has investigated the point, the patches on the conjuctiva are crowded with the saphrophytic organism, the xerosis bacillus.

The history of the second symptom, night-blindness, is often difficult to elicit from young children. Neither have we at our disposal any ready or accurate objective means of ascertaining its presence or absence in that class. In residential institutions, however, nurses and attendants not infrequently present a child for medical consultation because they have noticed him stumble about in twilight, or to knock into objects after the lights have been turned low in the dormitories.

The relationship between conjunctival changes on the one hand and night-blindness on the other is not invariable. The one symptom may occur without the other, and *vice versâ*. Indeed, the proportion of those with conjunctival xerosis who suffer from night-blindness varies according to time and place, and, for that matter, in the same place at different times. Thus, among eighteen cases of xerosis seen by me in 1895 at one of the largest London poor-law schools no fewer than 61 per cent. were more or less blind at night, whereas during 1896 and 1897, when nine cases of xerosis were respectively found, definite night-blindness appeared to be altogether absent.

At the same time, xerosis and night-blindness occur so often side by side that, as several authors have remarked, the association between them is likely to be something more than merely coincidal. Indeed, I shall now endeavour to show that the connection is much closer than is generally supposed.

In the course of investigations undertaken some years ago (1) I found that in children with xerosis, but without ascertainable night-blindness, there existed changes in the visual fields. These were of two kinds, viz. constant and inconstant. The former consisted in a reduction for the red and green fields. But that was not all, for the field for red is more shrunken than that for green, so that the former lay inside the latter, whereas under normal conditions the reverse should, of course, be the case. In three-fourths of the patients examined with reference to this point the transposition was complete, but in the others the two fields overlapped at one or more places. The second or inconstant change lay in a slight contraction of the limits of the field for white. In contra-distinction to this observation, Hepburn, in a recent communication (3) dealing with xerosis of the conjunctiva and night-blindness, states that in these cases "the fields of vision are invariably full," but Theodor Saemisch (6) mentions the occasional occurrence of the symptom.

Neither ring scotomata nor zonular defects were observed in any of my patients.

Now the changes in the visual fields, indicated rather than described above, may be found, as I have already said, in simple conjunctival xerosis as well as in xerosis associated with night-blindness, although they are more pronounced under the latter conditions. Moreover, the so-called "light minimum," as estimated by Förster's photometer, was diminished in both the conditions named. The obvious conclusion is that in both there exists a state of torpor retinæ. In other words, every child with the conjunctival

changes is in a condition of potential night-blindness, although obvious symptoms of that ailment cannot be discovered on a mere casual examination.

Furthermore, during my investigations I found a third point of connection to exist between the two conditions in the shape of changes in the fundus oculi. Both in simple xerosis and in xerosis complicated with night-blindness the fundus presented slight departures from normal. Thus, the retinal reflexes were exaggerated, so that the fundus looked paler than usual; while, in addition, a semi-circular jagged reflex was often to be observed close to the inner side of the optic disc. These points, although under any circumstances somewhat intangible, were easier to appreciate when ophthalmoscopic examination was conducted under weak illumination with an undilated pupil.

Most of the affected children I have examined appeared on a first view to enjoy good general health. They were usually well-nourished, while not a few had bright and ruddy cheeks. Bitot (5) noted as a singular circumstance that in the epidemic described by him among the inmates of the Hospice des Enfants Assistés de Bordeaux the ailment affected those in rude health, and spared for the most part the many scrofulous and rachitic inmates sheltered by the asylum. A somewhat similar conclusion was reached by Cohn (7) in 1868, and was repeated only the other day by Malcolm L. Hepburn (3).

A more attentive examination of my own cases convinced me that to not a few the old name "strumous" might fitly be applied. Such appearances as otorrhœa, large tonsils, opacities of the cornea, eruptions about face and ears, swollen upper lips, nasal catarrh, enlarged cervical glands, and synovitis of the larger joints were common among them.

Besides this, I found that the children with xerosis conjunctivæ, with or without night-blindness, showed a deficiency in the hæmoglobin content of the blood; for example, in fifteen cases hæmoglobin averaged only 65 per cent. of the normal. When the conjunctival changes had disappeared, the proportion was found to have risen, but never to par. This observation led me to inquire as to the possibility of Gower's hæmoglobinometer (the instrument I employed) being over-standardised. On this point I was unable to obtain any satisfactory information, and with the assistance of Mr. G. C. Burton, then resident medical officer at the Queen's Hospital, the point was investigated in 164 children, whose ages ranged from a few months to fourteen years. In every instance the percentage of hæmoglobin

fell below 100. It averaged 76·62 per cent., was slightly greater in males than females, and bore no definite relation to age. The exact figures have been embodied in an appendix to the present communication. One fact stood out clearly, namely, that the percentage of hæmoglobin was lower in children with than without xerosis conjunctivæ. Among the former the average was 65 per cent., while among the latter it stood at 76·62 per cent.

The red blood-count ranged from 70 per cent. to 134 per cent., and averaged 80 per cent.

From all this it follows that in xerosis, with or without night-blindness, the relationship between red cells and hæmoglobin—the so-called "colour index"—is generally reduced. To put the matter in another way, a condition akin to chlorosis, as determined by the blood, exists in the cases we are discussing.

Can we bring the several facts enumerated into line as accounting for the cause of this curious affection? I believe that we can. In the first place it is significant that xerosis and night-blindness should occur only in poor-class children, and should make their appearance exclusively in summer and autumn. Again, as regards any given institution, it is a matter of familiar observation to those acquainted with the circumstances that the brighter the weather the greater is the number of cases. The dazzling of sunlight, indeed, appears to be the immediate cause, and this is doubtless intensified by the ingrained habit of institutional children, who persist in running about the airing courts of the poor-law school, which are generally paved with York flags, without any protection whatever to the head in the shape of caps or hats. Anybody who has ever visited one of those places during summer weather will bear me out when saying that the flagged yards reflect an uncomfortable body of light into the eyes, apart altogether from the direct rays of the sun falling from above. The reflection from the white-washed walls, so common in those institutions, also, is doubtless not without influence. That boys suffer more than girls, a point first brought out by Bitot, is probably due to the relatively greater freedom enjoyed by the first-named class. For my own part, I do not believe in a true sex-incidence of the disease.

The white patches are to be found only on that part of the conjunctiva which is exposed to light when the eyes are open. This suggests that under the influence of light or of some of its elements, the metabolism of the exposed parts undergoes an alteration, and thus allows the xerosis bacillus, an almost constant inhabitant of the conjunctival sac, to lodge upon the parts and to multiply to an enormous extent. Particles of keratin and of keratohyalin are found

pathologically in the altered epithelium, and this leads, as Stephen Mayou (2) has pointed out, to an alteration in the surface tension of the affected areas, in consequence of which the oily secretion of the Meibomian glands collects upon them in the form of a white foam. But it is important to remember that the bacilli themselves play no part in the causation of the symptom-complex, although the contrary view has, of course, been held by more than one writer.

Last, but not least, the remote cause is to be sought in some slight defect of nutrition, as indicated by an alteration in the colour-index of the blood.

Finally, it should be said that recurrence is common in one and the same subject. Yet although this may happen during several successive summers, the ailment does not appear to entail any serious or permanent mischief, either as regards the eye itself or the body generally.

Appendix.

Estimation of hæmoglobin in 164 *healthy children.*

(Tested by means of Gower's hæmoglobinometer.)

Age.	Males.	Females.
1 year	83·5	75·0
2 years	73·3	—
3 „	70·0	73·0
4 „	73·3	75·0
5 „	73·8	76·3
6 „	74·0	76 4
7 „	74·0	73·7
8 „	79·0	75·0
9 „	77·7	75·2
10 „	78·3	82·4
11 „	76·3	72·0
12 „	91·0	80·4
13 „	81·8	78·4
14 „	77·0	73·0

Number of children examined 164 (ages 2 months to 14 years) { Males, 88. Females, 76.

Average hæmoglobin = 76·62 per cent., *i. e.* males 77·35 per cent., and females 75·83 per cent.

References.

(1) Stephenson, Sydney.—'Trans. Ophthal. Society U. K.,' 1898, xviii, p. 55.
(2) Mayou, Stephen.—*Ibid.*, 1904, xxiv, p. 9.
(3) Hepburn, Malcolm L.—*Ibid.*, 1910, xxx, p. 167.
(4) de Hubbenet.—'Annales d'Oculistique,' 1860, xliv, p. 293.
(5) Bitot.—'Gazette Hebdomadaire de Méd.,' 1863, x, p. 284.
(6) Saemisch.—'Handbuch der gesamten Augenheilkunde,' 1905, i, p. 443.
(7) Cohn.—'Ueber Xerosis Conjunctivæ,' Breslau, 1868.

MEDIAN CONGENITAL FISSURES, FISTULÆ AND DERMOID CYSTS OF THE NOSE.

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It is in the fourth week of intra-uterine life—a period of marked organo-genetic activity leading to the rapid construction of the embryo—that the first trace of a nose is visible.

The human face is formed by the union of several processes which grow forwards—the unpaired fronto-nasal process and the paired processes for the upper and lower jaws.

By the growth of secondary processes from the fronto-nasal process and the subsequent union of the lateral secondary processes with the maxillary process the nasal cavity becomes separated from the oral cavity.

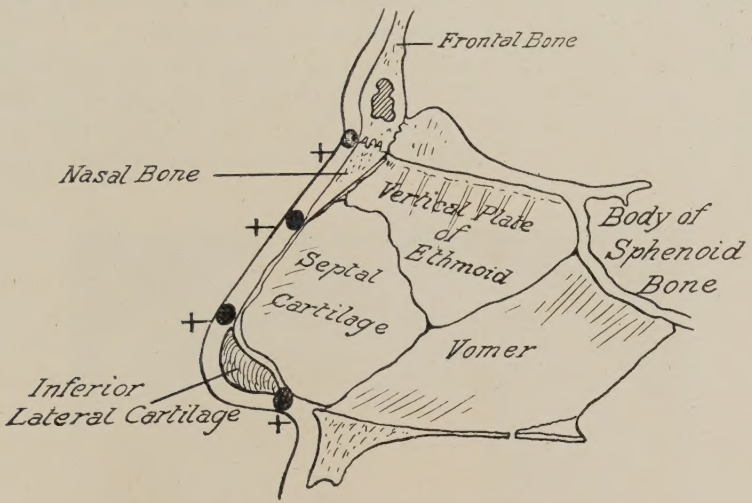
These various processes sometimes fail to unite—this failure of union may be complete or unilateral, and produces a varying series of "facial fissures or clefts," but in this short paper I only purpose speaking of those irregularities of union, or rather, fusion, which are seen in the median line of the nose, *e. g.* incomplete fissures, fistulæ, dermoids. These fissures evidence the bilateral and symmetrical origin of the nose, and are generally observed as a sulcus at the distal extremity only, though observers have recorded a complete median fissure (Poland, 'Pediatrics,' 1896, i, p. 401). The pathology of the embyro is evidenced chiefly in deformities or local irregularities and variations, because deformity is essentially the consequence of the local perversion of physiological growth.

Connected with irregularities in the complete fusion of the nasal units we find short depressions or canals lined with skin. These occur at definite points in the median line of the nose, and are

FIG. 1.—Median nasal fistula.

FIG. 2.—Median nasal dermoid.

FIG. 3.



● Situation of median dermoid cyst of the nose.
+ Situation of median dermoid fistula of the nose.

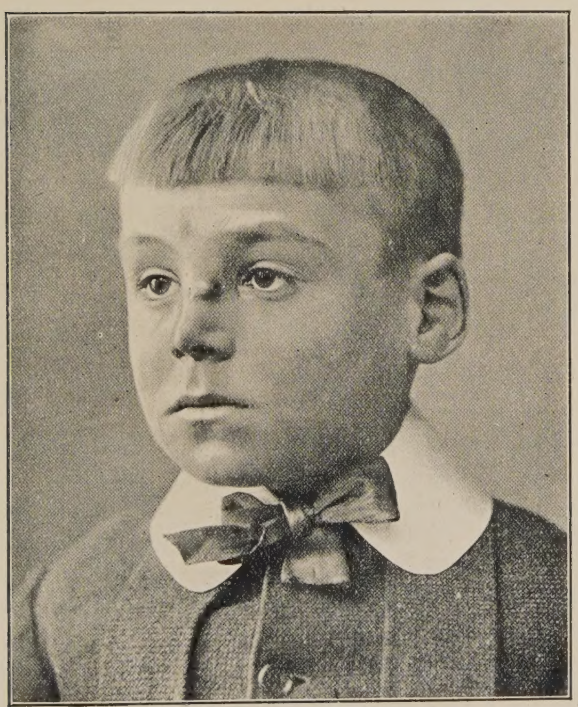


FIG. 4.—Median nasal fistula associated with dermoid cyst.

invariably situated at a little lower level than the corresponding cyst with which they may be associated or connected.

The co-existence of a median nasal fistula and a median nasal fissure suggests the question whether the occurrence of a fistula represents an incompletely closed fissure; undoubtedly the occurrence of a fistula in connection with a rounded swelling, whether

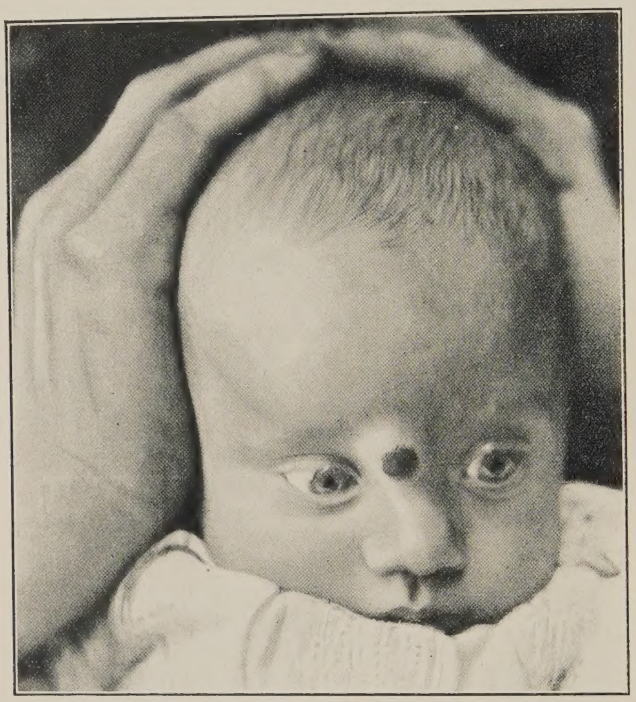


FIG. 5.—Median nasal dermoid cyst with overlying nævus.

situated in the median line of the nose or slightly to one side, clinically indicates the presence of a dermoid cyst.

Median fissure of the nose is less rare in some animals than in man; it may be viewed as the normal condition in some of the dogs employed in sport in this country.

As above mentioned, in cases of median nasal dermoid cysts, it is by no means uncommon to find a fistula leading upwards and backwards to the tumour; thus the closure of a fistula, including varying dermal elements, produces the dermoid.

At other times a free communication between the saccule and the

surface is shown by a secretion passing or expressible on to the surface.

Occasionally intra-nasal obstruction and a few rare cases of frontal sinusitis are due to dermoid cysts; analogous conditions—as I pointed out in the 'British Journal of Children's Diseases,' 1910, vii, p. 496—occur in relation to congenital cholesteomata of the internal ear.

But as these clinical features of the congenital irregularity only arise during adolescence and adult life I shall not consider them further on this occasion.

Whenever a nævus of the median line of the nose is associated with a rounded swelling which is incompletely compressible the clinician should expect to find a dermoid cyst present, and must not be totally unmindful of a meningocele.

I have not entered into the causation of these interesting anomalies, as the various hypotheses and theories connected with fistulæ and dermoid cysts will be found in a treatise shortly to be published; neither have I sought to meander into the physiognomist's fields of speculation, but in this short introductory article I have written in relation to certain embryological and anatomical points illustrated by definite clinical cases.

SURGERY AND ELECTRO-THERAPEUSIS IN INFANTILE PARALYSIS: AN ATTEMPT TO DEFINE THE SPHERE OF EACH.

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During the past twelve months it has scarcely been possible to pick up a medical paper without finding some reference to infantile paralysis. These references are, however, almost exclusively concerned with the acute stage of the disease. The experiments of Flexner and Lewis have proved the transmissibility of the virus concerned, and certain small epidemics in this country have turned the attention of our health authorities to a new field of labour. In the midst of all these activities directed towards a particular phase of the malady, there would appear to be a risk that the interests of the patients, once they are declared free from infection, may be to some extent neglected. Yet it is morally certain that for at least

another generation we shall have with us youthful cripples who owe their deformity to this cause. There is no immediate prospect of the discovery of a curative serum; and, as to isolation, if we are to judge from its effects as hitherto practised (for example, in the case of scarlet fever), this measure will not in itself suffice to check the epidemic spread of the disease, much less to prevent its sporadic appearance. Again, while scarlatina is well known to the public, and its rash looked on as a danger-signal, the constitutional symptoms of infantile palsy are often slight, and in many instances a doctor is not called in until the acute and infectious stage is long passed. Despite recent advances, then, the question as to the best method of dealing with the *sequelæ* of the disease remains of the utmost importance.

In former days it was the custom to take chronic cases either to the electro-therapeutist or to the nerve-specialist. These gentlemen seldom called in surgical aid. Now, the pendulum has swung violently, and such patients are generally brought to the ortho-pædic surgeon. He, likewise, regards his own methods * as all-sufficing. The truth is that neither, unaided, is competent to dea with every case. The disease in its chronic stage in reality presents two separate problems for solution—a vital and a mechanical. Surgical methods cannot stimulate sluggish nerve-cells, any more than electricity can correct a deformity due to permanent contracture.

In order to treat infantile paralysis on scientific lines, it is essential to know something of its pathology. That the malady is of the nature of an acute fever, having its local manifestations in the central nervous system, just as pneumonia has its focus in the lungs, is generally admitted. As to the precise nature of the causative organism, whether it be an ordinary coccus or something ultra-microscopic, we need not at present trouble to inquire. From the point of view of prognosis and treatment it is more important to know the nature of the lesion produced. The older view was that the mischief consisted in an inflammation arising in, and practically confined to, the large motor-cells of the ventral horn of the spinal grey matter. Hence the term "anterior poliomyelitis"—a name which can no longer be said to explain the modern conception of the nature of the disease; for recent investigation has shown that, on the one hand, the inflammatory condition involves the whole of the grey matter, sometimes even the meninges; while, on the other,

* The employment of massage, exercises and apparatus is taken for granted in both cases, as no one who has to deal with infantile palsy would be so foolish as to neglect their aid.

it is the *blood-vessels* which are primarily concerned, the nerve elements suffering indirectly from pressure or starvation. The electro-therapeutist has long held, from clinical observation, that an attack of infantile palsy, while utterly destroying many cells, leaves others, as it were, in a state of suspended animation, from which they can be aroused only by electrical stimuli. The fact that the motor neurons are not attacked *ab initio* furnishes a pathological argument in favour of this view.

In most writings on infantile paralysis attention is devoted almost exclusively to the effects of the disease on muscles and their governing nerves. Sensation is stated to be unaffected; but, as I have shown elsewhere,* in severe cases the pain sense, and less frequently the capacity to distinguish heat and cold, are liable to be impaired. Were these the only other elements concerned, neglect to emphasise their involvement might not matter much from the clinical point of view; but lack of attention to the effects of the disease on *growth* and *development* is responsible for many therapeutic failures. That muscular palsy is often accompanied by a general shrinking of the affected limb is well known; what is not so generally recognised is that any of the following variations may occur:

(1) The limb may be considerably smaller than its fellow without much impairment of its motor functions.

(2) With severe palsy the limb may nevertheless remain of normal length, keeping pace with the sound side.

(3) In the case of a diseased upper segment—say a thigh—the lower segment (leg) may grow *longer* than the corresponding portion of the undamaged limb.

These facts would seem to be most readily explained by assuming the existence of separate spinal cells controlling growth and development, capable of suffering either more or less than the surrounding motor cells, or even of being stimulated into abnormal activity. Whether or not this be so, the control of growth is, if not physiologically, at any rate clinically separable from that of movement. Hence, treatment directed solely to mechanical ends—whether by correcting deformities or strengthening individual muscles—cannot of itself suffice for the requirements of all cases.

In the opinion of the present writer, every case of chronic infantile palsy should be taken in the first place either to the electro-therapeutist, or to the neurologist who makes use of electrical methods in his treatment. It is for them to determine, so far as

* 'Med. Press and Circ.,' 1910, ii, p. 187.

may be, what muscles are beyond hope, and to what extent recovery may be expected in the rest. In electricity we have the only agent capable of stimulating defective growth ; this fact alone places those who use it with skill in a position of peculiar strength. But it is incumbent upon the physician in this, as in so many other branches of medicine, to know his own limitations, and never to let a false pride prevent him calling in the aid of his surgical colleague.

As regards the remedial measures to be employed, cases of chronic infantile paralysis are divisible into four groups : (*a*) Where surgical treatment is useless ; (*b*) where some operative procedure must be undertaken before other methods can be of value ; (*c*) cases in which surgery offers the only hope of improvement ; (*d*) a large group consisting of border-line cases, where medical treatment should be given a reasonable trial.

The following is an example of the first class :

A girl, aged 9 years, had suffered from an attack of infantile palsy at the age of three years. The right lower limb was at first completely disabled, but eventually recovered to a considerable extent. Walking was possible for short distances, but was followed by such severe aching pain that the child was practically confined to the house. The limb was somewhat shrunken, there were two inches of relative shortening, and all the muscles of the thigh and hip were markedly paretic (Fig. 1). The daily application of the faradic current for three months completely restored the functions of the limb, and the child can now walk for miles without fatigue. A year after the cessation of treatment the leg was almost as stout as its fellow, and the relative shortening, which had previously become steadily worse, was reduced to one inch (Fig. 2).

This patient, before coming to me, had received a long course of massage combined with sea-bathing. It had not been possible, however, to employ exercises, as the slightest exertion caused the characteristic dragging pain. For the use of apparatus there was no field, nor yet any call for surgical interference. One is therefore justified, I think, in claiming that in cases of this type electricity is the only agent capable of accomplishing a cure.

We may ask, under what circumstances is a surgical operation necessary before other measures can be effective ? A girl, aged 6 years, was brought to me suffering from the after-effects of an attack of infantile palsy in the left lower extremity. Contractures of the flexors of the hip, combined with shortening of the gastrocnemius, had contorted the limb till it was quite useless, and locomotion was possible only by the aid of crutches. I called in

Mr. F. C. Pybus, of Newcastle-on-Tyne, who divided the necessary tendons. Even after this the leg could not be pulled straight, and there was no voluntary power to extend the thigh in the pelvis. Faradic reaction in the glutei was at first only obtainable with very strong currents under an anæsthetic, but persistent treatment for three months enabled the patient to swing the limb normally from the hip. A boot was devised to support the still weakly knee-joint, and the child now *walks* with the aid of a stick

Fig. 1.

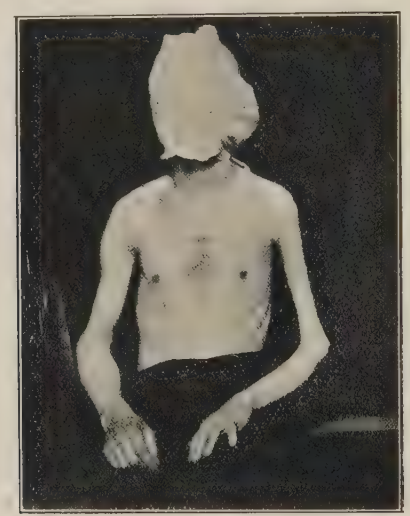
Fig. 2.

only. I have not space to go into the details of this very interesting case, but I would like to make this comment on it: that it belongs to a type which, if properly treated from the first, should never need the ministrations of the surgeon. For contractures and deformities are *preventable*, in the first place by suitable apparatus, and secondly, by the stimulation of those muscles which by their weakness permit of over-action on the part of healthy opponents.

Fig. 3 illustrates a case where surgery offers the sole hope of betterment. This man, aged 28 years, has the left biceps, triceps, and most of the deltoid reduced to thin sheets of fibrous tissue. The hand is capable of grasping, but is practically useless owing to the condition of "flail elbow." Some operation designed to immobilise the joint in a semi-flexed position may prove of benefit.

There remains a large number of cases in which it is at first impossible to say whether or not surgical procedures will be necessary. Every muscle not hopelessly fibrosed should be given a course of electrical stimulation; and this stimulation should be persisted in for at least three months. On the other hand, the lengthy periods mentioned in some text-books on electro-therapeutics —two years and upwards—are for the most part beyond what is practicable, and seldom likely to be of much benefit. Cases which may ultimately have to be handed over to the surgeon are those in

Fig. 3.



which, owing to persistent paralysis of some important muscle or muscles, a useful result cannot be obtained even with the aid of apparatus. The procedures open are—(1) tendon-grafting; (2) nerve anastomosis; (3) arthrodesis. For a description of these the reader is referred to special surgical works. They are highly complicated operations, and their performance should not be lightly undertaken by anyone not familiar with this particular work.

Before giving his consent to operative interference the physician should, however, get the surgeon to explain in a general way what it is he purposes attempting. If tendon-grafting is to be employed he should ask himself whether the "reinforcing muscle" is likely to be strong enough for its new work. He should also try to determine—in the case, say, of a wasted lower limb—how much of

the existing disability is due to general flabbiness, and how much to the lack of the particular movement which it is proposed to restore. Unfortunately, as is only too well known to those who have to do with the designing of apparatus, the correction of some glaring fault does not always produce the benefit which might have been anticipated.

As to nerve anastomosis, the ultimate results seem to be in many instances beyond the wit of man to foretell, and while this operation may have a future before it, at present it should be looked upon as a *dernier ressort*.

Nor should arthrodesis—the artificial locking of a joint—be undertaken hastily. The union is not seldom so weak that supporting apparatus is permanently necessary; and in the case of some articulations, such as the knee, the resulting stiff limb is extremely inconvenient to the patient.

In conclusion, it may be of service to inquire why the surgeon and the electro-therapeutist so often look upon each other with mutual distrust. I will first state what I believe to be the surgeon's reasons for regarding his colleague with scant approval. Briefly, it is because he sees cases treated in the electrical department which could obviously benefit by such treatment, if at all, only after a preliminary surgical operation. And, further, because many cases, even where no deformity exists, do not seem to derive much benefit although treated for several months. The electro-therapeutist also has to pay the penalty for extravagant claims made in the past. In the article on "Infantile Spinal Paralysis" in the 'Medical Annual' for 1899 occurs the following statement: "Electricity is the only remedy of value in this disease; it should be employed in the form of the continuous current; Faradism is useless." Such narrow-mindedness on the part of its exponents, combined with faulty selection of cases, unskilful technique and lack of personal supervision, has brought much undeserved discredit upon electrical treatment, whether directed to infantile paralysis or to disease in general.

Coming, now, to the other side of the question, it is possible to frame a very grave indictment against the surgeon. The head and front of his offending is that he condemns what he does not understand; and despises the opinion of men who have made a life-study of therapeutic methods which certainly do not call for less intelligence than does the exercise of his own craft. The authors of a well-known work—excellent in so far as it deals with the details of operative procedures—take upon themselves to discredit electricity.

Speaking of *massage*, they say: "The mother, nurse, or maid can in a few minutes be taught all that is necessary to be learnt." Now, if the electrical technique of the writers has been acquired with a like phenomenal rapidity, we need perhaps seek no further for an explanation of their views.

The tendency of the surgeon is to take a purely mechanical view of the non-functioning of a paralysed limb. He does not even pretend, so far as I know, that any of his methods will *stimulate the growth of a limb as a whole*. Before considering seriously his denial that electricity can arouse torpid nerve-cells, one is entitled to ask, Is he familiar with the experiments of Debedat with faradic currents on growing rabbits? Has he watched X-ray treatment of cancerous axillary glands, and noted the enormous development of the arm on the affected side? The experiments of Lazarus Barlow and others have proved that radium can stimulate the growth of animal cells. Does the surgeon know that by the method of Haret radium ions can be driven through the bone into the spinal marrow? Above all, has he studied carefully, and without prejudice, the records of cases treated solely by the electro-therapeutist?

The answer to these questions must frequently be a negative one. I hasten to add, and do so gratefully, that many eminent surgeons are ready to investigate impartially any line of treatment which promises benefit to humanity, even though it runs counter to their own previously expressed views. With such the electro-therapeutist should seek to work in harmony; for it is only by the whole-hearted co-operation of surgeon and physician that many crippled patients can be restored to usefulness and health.

ANEURYSM OF THE DESCENDING BRANCH OF THE RIGHT CORONARY ARTERY, SITUATED IN THE WALL OF THE RIGHT VENTRICLE, AND OPENING INTO THE CAVITY OF THE VENTRICLE, ASSOCIATED WITH NON-VALVULAR INFECTIVE ENDOCARDITIS AND DILATATION OF THE RIGHT CORONARY ARTERY.*

By R. Salusbury Trevor, M.B.,
Pathologist to St. George's Hospital, London.

A girl, aged 11 years, was admitted into St. George's Hospital on September the 4th, 1911, under the care of Dr. Latham.

* Specimen shown at the Section for the Study of Disease in Children of the Royal Society of Medicine, October the 27th, 1911.

The history of the case was as follows : Seven days prior to admission she caught a "chill" while bathing. This was followed by a rigor, sweating, and pain in the left knee. For three days prior to admission there was soreness of the throat, and the legs became swollen. The only previous illness was measles six years ago.

On admission the child was flushed and restless, with a temperature of 102° F., pulse 108, and respiration-rate 28. There was no pain in, or swelling of, the legs. The heart's apex beat was diffuse, in the sixth space, 1 in. external to the nipple line. The area of cardiac dulness extended 1½ in. to the left of the nipple line but not to the right of the sternum. A rough systolic mitral murmur and thrill were present. The murmur was best heard 1½ in. internal to the nipple line. The lungs and abdomen were natural.

On September the 8th, four days after admission, a red, tender swelling appeared at the right great toe-joint. There was no reaction to salicylates. Temperature 104° to 105° F. The heart condition was as on admission.

On September the 11th streptococci were found in the blood and a vaccine was prepared. Polyvalent serum was given in the meantime.

On September the 14th a to-and-fro cyclical murmur, which was very rough and scratchy, became audible, and was best heard over the tricuspid area, but was conducted over the entire præcordium.

On September the 16th there was evidence of rapid dilatation of the heart, temperature remaining about 104° F.

On September the 19th the patient died.

The diagnosis made was infective endocarditis and pericarditis.

I examined the body thirteen hours after death. It was fairly well nourished. The legs were slightly œdematous. There was bilateral sero-fibrinous pleurisy with a small quantity of turbid effusion in each pleural cavity. Both lungs overlapped the pericardium, to which the pleura was lightly adherent. Both lungs were œdematous and contained numerous septic infarcts. There was general bronchitis. The infra-tracheal and bronchial glands were free from tubercle. In many of the intra-pulmonary branches of the pulmonary artery there were tough adherent ante-mortem clots. The pericardium was normal. The heart weighed 10 oz. and was rounded in shape. Both ventricles were dilated, the right one being especially so. The muscle in the fresh state was cloudy and pale. The heart-valves were free from vegetations, and they were all thin and flexible, with the exception of the posterior flap of the mitral, which showed slight thickening. In the cavity of the right ventricle, just to the inner

side of the anterior papillary muscle, was an adherent mass of clot, guarding at its lower end a rounded or oval opening, with a maximum diameter of ¼ in., leading into the interior of a prominence on the postero-lateral wall of the ventricle. The edges of the opening were rough, and the surrounding endocardium apeared ulcerated. The prominence was caused by a thin-walled fusiform aneurysm of the descending branch of the right coronary artery, situated within the muscular wall of the right ventricle. The sac was of about the size of a damson or a small plum, and the lining membrane bore some rough adherent clot at its upper part and was ulcerated below at the opening into the right ventricle. The right coronary artery was remarkably dilated. Its opening in the right sinus of Valsalva measured ½ in. across and admitted the little finger easily, and the lumen continued of large size to the point where the descending branch was given off. Beyond this point the lumen ended almost blindly, two fine holes indicating the continuation of the vessel along the auriculo-ventricular furrow. The artery showed no evidence to the naked eye of any acute inflammatory change, nor was acute endarteritis present on histological examination. The left coronary artery was normal at its commencement and showed no obvious dilatation. The aorta above the valves showed a few patches of atheroma. Its branches were given off normally, and no abnormalities in the rest of the vascular system were discovered. The abdominal organs showed cloudy swelling, and there was no ascites. The right knee-joint was healthy; the right great toe-joint was unfortunately not examined.

Aneurysm of the coronary arteries of the heart is an uncommon lesion, and one which in consequence receives but scanty treatment in the text-books. This is the first case which has occurred during the last ten years in St. George's Hospital among a little over 3000 post-mortem examinations.

In the 'Transactions of the Pathological Society' there are records of three cases, two being cases of multiple aneurysms, and one of a single aneurysm of the left coronary artery in a man, aged 50 years. In this case the artery showed extensive calcareous changes and the aneurysm was practically filled with clot. In the case described the physical signs suggest that the communication of the aneurysm with the right ventricle occurred five days before death, and coincided with the onset of the to-and-fro murmur which was thought to have been due to pericarditis. The date of the occurrence of the aneurysm itself can only be a matter of speculation. The impression which has been left on my mind is that it is of old date. It is on

the whole smooth-walled, but the wall is remarkably thin. No communication between the artery and any of the cardiac veins can be made out.

With regard to the remarkable dilatation of the coronary artery itself, it does not seem probable that this can date from the time of rupture of the aneurysm into the ventricle. Yet it seems certain from the differences of pressure within the two ventricles that at this time the blood must have passed from the left ventricle *viâ* the coronary artery into the right ventricle, and this being so, it may be that there was a larger blood-flow through the artery. This may have led to dilatation; but the length of time, viz. five days, does not seem sufficient to have allowed any dilatation to have assumed the size found post mortem.

The only other explanation I can offer is that the artery was anomalous at birth. If this were so, it would favour the entrance into it of septic emboli, which might perhaps account for the aneurysm found. The condition present produced clinically a murmur in many respects similar to that associated with persistent ductus arteriosus.

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Royal Society of Medicine.

SECTION FOR THE STUDY OF DISEASE IN CHILDREN.

Friday, October the 27th, 1911.

Dr. G. A. Sutherland, *President, in the Chair.*

A Case resembling General Paralysis of the Insane.—Dr. Porter Parkinson showed a girl, aged 9 years. The mother had had several miscarriages. The child had had no previous illness except slight snuffles in infancy. About four or five months ago she was noticed to be walking badly, especially on the right leg, and occasionally turned giddy and faint. From being a good-tempered child she became very irritable and spiteful. Her speech was indistinct, and her mental processes slow. There were none of the stigmata of hereditary syphilis except the remains of an iritis from which she suffered three months ago. The pupils were unequal, and their reaction to light and accommodation sluggish. The movements of the limbs

were unsteady, but there were no tremors of the hands, lips or tongue. Romberg's sign had been present, but at the present time she could stand with the eyes closed. The Wassermann reaction was positive in the blood, but negative in the cerebro-spinal fluid. A distinct improvement followed mercurial inunctions.

The general opinion was that it was impossible to state definitely whether the case was one of general paralysis of the insane, or one of diffuse cerebral syphilis.

Two Cases of Partial Subluxation of the Knee-joints with Voluntary Production of a Noise during Flexion and Extension.—Mr. O. L. Addison.

Case 1.—Boy, aged 9 years, an undersized child. Marked genu valgum, exostoses at upper end of both tibia, and hyperextension of both knees. Flattening of chest, beaded ribs, and enlarged epiphyses at wrists. Breast-fed child; quite well till four years ago; since then has had recurrent attacks of bronchitis, measles, and pneumonia two years ago. The legs were only noticed to be crooked two years ago, and have been getting worse since.

Case 2.—Girl, aged 6 years, breast-fed. Healthy till two years of age. Since then she has had frequent attacks of bronchitis, measles, and pneumonia two years ago. Legs became bent after measles, and have been much worse lately. Patient shows a condition like that of the brother, except that the genu valgum is not so great, no exostoses are present, and the noise produced in the knee-joints is not so loud.

Infantilism.—Dr. G. A. Sutherland.—Girl, aged 16 years. She seemed normal in every way until the age of six years, when growth ceased, rickets appeared, and constipation became very marked. Teething was normal as regards time, but the teeth were very soft and crumbled away. Measles at the age of two years. The rickets led to a waddling gait and much bending of the bones, for which she has been at an orthopædic hospital.

(*a*) Infantilism: Appearance, talk and intelligence that of a child of six years. Only two teeth of second dentition.

(*b*) Persistent rickets: Bones of extremities much distorted, epiphyses thickened, chest rachitic.

(*c*) Abdomen very large and superficial veins prominent. At times peristaltic waves visible in the region of the colon. Bowels do not act without enemata or aperients. Great fæcal accumulation takes place, palpable over whole of abdomen when bowels not carefully regulated.

(*d*) Urine: Specific gravity 1000 to 1005; no albumin or casts; occasionally marked retention of urine without discomfort; polyuria; polydipsia; radial and brachial arteries thickened; arterial pressure, 120 mm.; no retinal changes; skin pigmented; heart somewhat dilated, but no marked accentuation of sounds. Wassermann reaction negative.

Extreme Rickets and Infantilism.—Dr. G. A. Sutherland.—Girl, aged 6 years. Child was born healthy, and fed on the breast for eight months: after that cow's milk and water and bread. Had a fright at the age of $2\frac{1}{2}$ years and since then never strong. Has had measles and attacks of diarrhœa. Five other children in the family said to be healthy.

Child was in an extremely neglected condition when admitted, very

exhausted, lethargic, and suffering from constant cough. Physical development was much retarded, her appearance being that of a child of three years. Marked rachitic changes in the bones of the upper extremities and of the thighs. Greenstick fracture of both bones of right forearm. Both scapulæ are small; show thickening of bone in lower part, and bending at inferior angle. Some of the upper ribs are subluxated from their costal cartilages and displaced backwards. Marked spinal curvature. Heart displaced, apex felt in upper part of left axilla. Abdomen contains some free fluid. Deficient entrance of air and impaired resonance right lung, and some scattered bronchi over both lungs. Von Pirquet's reaction negative. Fingers clubbed. Great sweating, especially about the head.

Sclerodermia with Myositis Fibrosa.—Dr. Langmead.—The patient, now aged 1 year 8 months, was shown before this Section just twelve months ago, and is reported in the 'Proceedings' for November of last year. Since birth, or shortly afterwards, the skin has been noticed to be tense and hard, and the movements of the body, especially of the limbs, to be greatly restricted. She cannot completely close her eyes at times, whilst the mouth is usually open. The usual expressionless aspect of sclerodermia is present. Sclerodactyly is marked. The muscles are rigid also, and feel like leather bands, accounting for much of the fixity of the limbs. During the last twelve months she has grown considerably, and has seemed well in general health. The condition seemed to be improving until August, when she developed pneumonia, the result of which has been to accentuate it, as far as can be determined by examination.

Sclerema.—Dr. Langmead.—Girl, aged 10 months, shows the more common type of hardening of the skin and subcutaneous tissues found in infants. She is the only child. The father is blind, and aged 37 years; the mother, aged 40 years. She was first brought to the hospital when aged 7 weeks for persistence of the posterior fontanelle, which was widely patent, and a patent occipital suture. These have now closed. In June last a brawny condition of the cheeks and legs was first noticed which has persisted since; it followed an attack of severe diarrhœa.

Intra-uterine Fracture of Tibia and Fibula, with Absorption of Bone.—Mr. Maynard Heath.—Baby, aged 4 weeks. At birth the left leg was noticed to be shorter than the right below the knee. On examination the shortening is very obvious. There is a bowing forward of the leg at the junction of lower and middle thirds and a corresponding groove in the soft parts on the posterior aspect. The bones in the situation of the prominence can be felt to be irregular and there is free mobility between the upper and lower portions of the leg at this point. The circulation in the foot is good, and there are no other deformities. The child was born head first without much difficulty, and no structure was found constricting the leg. X rays show a fracture of the shaft of the tibia, with a considerable area of rarefied bone around it. There are similar areas of rarefaction about the lower extremities of the tibia and fibula.

Gigantism of Forepart of Foot.—Mr. Maynard Heath.—Girl, aged 6 years. At birth a deformity of the right foot was noticed. At the age of three months the enlarged second toe was amputated. Since then the forepart of the foot has grown more than the rest of the body. The great

toe is now deflected inwards but not much enlarged. The third toe is very large and deflected outwards. Between these two toes is a rounded, elastic, firm swelling, more pronounced on the sole than the dorsum, and in the former situation extending almost to the middle of the foot. At the summit of the swelling is the scar of the previous operation. There are no other deformities and no history of similar overgrowth in any members of the patient's family.

Double Third Nerve Palsy due to Acute Polio-encephalitis in a Boy, aged 7 years.—Mr. Payan Dawnay.—The illness commenced about the third week in August with vomiting, fever, constipation and some delirium at night. He was ill for about a fortnight. He was said to have told a playmate just before he was ill that he saw double. When Mr. Dawnay first saw him on September the 9th the condition was as follows: Marked ptosis on both sides, elevation of the lids only by the action of frontalis, no power of elevation or depression of the globes, fair lateral movements with complaint of occasional diplopia to the right. Pupils equal and active directly and indirectly, no paralysis of accommodation. There were no other signs of paralysis.

Recurrent Unilateral Œdema in a boy, aged 14 years.—Dr. T. R. Whipham.—For the last three or four years the right leg had swollen once a year, generally in the month of September. There had been twice swelling of the right arm, but not at the same time as the leg was affected. In the recent attack the right leg and foot were swollen and the right side of the face was a little puffy. On the inner side of the calf was a purpuric patch, giving the sensation to the fingers of obstructed lymphatic vessels. The extremities were all cold and of a bluish colour, these features being especially marked on the right leg. The right hand was a little puffy. The viscera were normal, the urine contained no albumin, and the temperature has been normal throughout.

The following pathological specimens were shown:

Diphtheria of Œsophagus.—Dr. J. D. Rolleston.—Boy, aged 2 years 4 months, was admitted moribund to hospital on October the 14th, on eleventh day of disease, and died in seven hours. No antitoxin had been given, diphtheria not having been diagnosed until day of admission.

Condition on admission: Profound toxæmia, pulse imperceptible, temperature 97·6° F. Old membrane visible on tonsils, uvula, and epiglottis, pronounced oral fœtor, profuse blood-stained nasal discharge. Slight stridor, croupy cough, and recession. Upper part of right external ear swollen and excoriated. Sloughing wound just below left external malleolus. Cultures of throat, ear, and wound all showed abundant Klebs-Löffler bacilli.

Specimen of Œsophagus: Upper third normal; middle third shows some injection of mucosa; in lower third are two longitudinal areas of necrosis measuring each 3·5 cm. in length, coalescing below, where they measure 2·2 cm. in width, and stopping just short of the lower end of the œsophagus. In the centre of one of the areas the muscular wall of the œsophagus is exposed. Direct smears and cultures from the necrotic areas showed numerous Klebs-Löffler bacilli.

(1) **Aneurysm of the Right Coronary Artery, situated in the Wall of the Right Ventricle, and opening into the Cavity of the**

Ventricle, associated with Non-valvular Infective Endocarditis; (2) Congenital Morbus Cordis (Cor Biatriatum Triloculare).—Dr. Salusbury Trevor.—The specimen was obtained from the body of a male infant aged 4 days. The child was of good colour and showed no evidence of disease during its short life. It died suddenly in a fit.

The principal anomalies shown were: (1) a single ventricular cavity formed largely from what should be the right ventricle; (2) a single auriculo-ventricular valve with three flaps communicating with the right auricle; (3) a single main arterial trunk taking the course of the aorta and giving rise to the right and left pulmonary arteries, the innominate, left common carotid and left subclavian arteries; (4) a very large right auricle with patent foramen ovale; (5) a rudimentary left auricle communicating with the right auricle, but not with the single ventricle, and receiving two sets of veins fused into a single trunk from each lung.

On Cases of Night-blindness with peculiar Conjunctival Changes in Children.—Mr. Sydney Stephenson.—This paper dealt with a curious class of case not uncommon during the summer months in institutional children, where white frothy patches on the ocular conjunctiva were or were not associated with symptoms of night-blindness. The author had found that under either circumstance the field of vision manifested slight changes, the light minimum was diminished, the fundus oculi showed changes, and lastly, the colour-index of the blood was lower than normal. Mr. Stephenson believed the immediate cause of both affections was the dazzling of sunlight, and their remote cause some slight defect of nutrition, as evidenced by the changes he had found in the blood.

Philadelphia Pediatric Society.

October the 10th, 1911, J. Torrance Rugh, M.D., President.

DERMATOLOGICAL DEMONSTRATION.

Dr. Leonard D. Frosseln, by invitation, demonstrated microscopic specimens of the causes of various skin diseases. He said that in cutaneous disease, as in internal constitutional affections, the keynote to successful management lay in the ætiology. Whereas the specific causes of many diseases, *e. g.* typhus fever, was still obscure, and the ætiology of psoriasis, pellagra, morbilli, rubella, variola, and varicella was still under discussion, the offending agent in favus, pediculosis, scabies, tinea, equinia, anthrax, actinomycosis, syphilis, etc., had been found. Scrapings had been made with a view of determining the cause of measles and chickenpox without success.

Saprophytic bacteria, moulds and animal parasites entered into the ætiology of various skin lesions, *e. g.* Fehleisen's streptococci in erysipelas; staphylococci in sycosis, acne and furunculosis; tubercle and lepra bacilli; blastomyces fungus; Vincent's organisms on mucous membranes; Klebs-Loeffler's bacilli; Ducrey's bacilli in chancroidal infections of skin and mucous membranes; wood-ticks, mower's mite, bot-fly, fleas, mosquitoes,

jiggers, bedbugs, and the *Pediculoides ventricosus*, which caused the "straw itch." The last animalcule was found in the siftings of new mattresses. Several moulds and animalculi were shown, particularly tricophytosis and pediculosis (better termed phthiriasis). The *Acarus scabiei* belonged to the Sarcoptes family, was quite small, and very difficult to demonstrate. There were various forms of the trichophtyton fungus (ringworm), large spore, small spore of Sabouraud, *Microsporon Audouini* in ringworm of the scalp, the ectothrix found in the cat. The fungus had many rods with swellings, mycelia and spores, $\frac{1}{1000}$ to $\frac{1}{600}$ inch in diameter. *Microsporon furfur* was the cause of tinea versicolor, which was rare in children. These mycelia were slender and branched, and the spores measured $\frac{1}{900}$ to $\frac{1}{300}$ inch in diameter. The *Achorion Schoenleinii*, the cause of tinea favosa (favus), was discovered in 1839 by Remak. Quincke and others spoke of several varieties. The spores were about $\frac{3}{1000}$ mm. in diameter, and could be seen with 300 to 500 diameters. The threads were broader and joints more numerous than in ringworm. Some observers found it difficult to distinguish between them.

Pediculi ranged from 1 to 3 mm. in length. There were three varieties: pubic louse, the smallest; head louse, the nits of which hatched in three to eight days; and body louse, largest, with nits hatching in about six days.

Dr. Frank Crozer Knowles presented eight cases—one extensive vascular nævus, two cases of ringworm of the scalp, four cases of psoriasis, and one of urticaria pigmentosa. The vascular nævus showed the excellent result obtained by the application of carbonic acid snow. The infant, aged 4 months, was born with a large vascular nævus, involving half of the forehead, the nose and upper lip, including the mucous membrane. The snow, which had a temperature of 79° C., was collected in a chamois bag, and hardened under pressure into a mould conforming to the area to be treated. Four treatments had been given, varying from ten to fifteen seconds, with fairly firm pressure. The face was almost entirely cured, only three or four very small areas of vascular lesions remaining. The site of the vascular nævus now showed a smooth, thin, white scar.

Two patients were exhibited with different types of ringworm of the scalp—the non-inflammatory and the inflammatory. The former, tinea tonsurans, was caused by the *Microsporon Audouini*, the other, tinea kerion, was produced by the large-spored variety of the trichophyton. When other remedies failed X rays could be used, a Sabouraud-Noiré pastille being used as the indicator of the correct dosage, or a fifteen-minute exposure to the X rays should be administered, the tube being fairly soft, and eight to ten inches from the area should be treated.

It was unusual to be able to present four cases of psoriasis in early childhood, each with extensive and active eruptions. One was only three years old. Another unusual feature was the occurrence of this condition in a brother and sister, each in the active stage. All four were typical cases in form and distribution.

Urticaria pigmentosa was a rare disease. Dr. Knowles had seen four cases in over twenty thousand skin eruptions observed during the last nine years. The condition usually started in early life, being first noticed as a typical attack of urticaria of chronic duration. Pigmentation remained, however, at the site of the attack. Prince Morrow, of New York, had had such a case under observation for over twenty years. In the present case, a girl, aged 8 years, the eruption had lasted eighteen months. She had a number of pigmented spots, sites of former urticaria wheals, on the chest

and upper portion of the back, somewhat generalised in distribution. The tendency to wheal formation had practically ceased under careful regulation of the diet and remedies correcting the gastro-intestinal symptoms. Wheals, however, could be readily produced by stimulating the skin with a blunt instrument. Itching had been intense, but had been much improved by the application of anti-pruritic lotions and dusting powders.

Dr. William Penn Vail showed two cases of scabies. He said that scabies was a widespread parasitic disease, affecting all ages, both sexes, over the entire world. It was seen in dispensary practice in larger numbers than in private work, being the most frequent skin disease seen at the St. Louis clinic, Paris. It was caused by the presence in the deeper part of the corneal layer of the epiderm of the *Sarcoptes scabiei* or *Acarus scabiei*, an animal parasite, whitish and shiny in colour and rounded. While the female mite was visible to the naked eye, the male was smaller. Females were much more numerous than males, and when fecundated penetrated into the epiderm, making a burrow in which they deposited ova, from six or nine up to thirty in number. The mite could not retreat because of several bristling hairs projecting from her body; she died in the burrow. The eggs matured in a few days, and the resulting larval forms emerged upon the surface and became sexually active, were impregnated, burrowed, deposited ova and died, and thus the cycle continued. The life of the individual mite was said to be from two to three months. Males lived on the surface near the burrows, which were seen as grey lines persisting after washing, 2 to 3 mm. or more in length. The burrow rarely branched, but often had an undulating zig-zag form, at times like the letter **S**. The mite was often seen as a mere shining, white area at one end of the burrow. From this point she could be removed with a needle. Ova and dark fæcal matter might be seen in the burrow. It was not always easy to find the burrow or to capture the mite, especially when there was much dermatitis, a variety of lesions, or eczema or impetigo also present. A great variety of lesions, papules, vesicles, pustules, crusts and perhaps furuncles, lymphangitis, suppurating adenitis existing side by side, generalised over trunk and limbs, were most suggestive of scabies. The location of the multiform lesions aided in the diagnosis, as the mite preferred parts where the skin was thin and soft. Thus the face and scalp of young children were generally exempt. The sites of election were the web and sides of the fingers, wrists, anterior surfaces of the forearm, under the breasts, on the prepuce and glans penis, about the umbilicus, the gluteal region, anterior axillary region, dorsum of the foot, about the malleoli, and in children the soles of the feet and palms of the hands. In addition there was always itching, much worse at night when the patient was warmly covered, for then the mite started to burrow. Scratchmarks, dermatitis and secondary infection followed. Inquiry revealed the presence of a similar case in the family or among the patient's friends. Often an entire family had the disease, for it was transmitted only by contact, direct or indirect. Scabies might be transmitted from horses, cats or dogs to man, but the parasite was of a foreign type and the malady was cured by cleanliness and medication. At first there was slight itching; this became worse, and in two weeks the disease was full blown. Untreated it continued indefinitely. During a concomitant acute illness the adult parasites seemed to die, but the ova developed soon after fever subsided.

In the treatment sulphur was commonly used, one to one and a half drachms to the ounce of ointment, rubbed in thoroughly after a hot soap and water

bath. This was repeated for three more nights without the preliminary bath; then on the fifth night a second warm bath was taken. Infected clothing was to be boiled for half an hour or baked in an oven at 120° C. Beta-naphthol, balsam of Peru, styrax, Hardy's modification of Helmerich's ointment and Hebra's modification of Wilkinson's ointment had been used with success.

Dr. Edward F. Corson showed three cases of eczema, the most common of all skin diseases. Causative agents were more numerous in children than in adults. Some underlying error in digestion was usually found with constipation. A rheumatic family history was frequently obtained. The child ate too much and got too little exercise, or the character of the food might be at fault. Besides, other skin diseases might have eczema implanted upon them. External causes were cold, dryness, heat, strong soaps, hard or ordinary water, chemicals, scratching, irritating discharges, dirt, rough clothing, dyes, etc. The varieties were numerous, according to the type of the lesions. The common sites for the eruption were face, scalp, buttocks, flexures of elbows and knees, forearms and chest. The ears, neck, and other parts of the body might become affected. Improvement easily followed appropriate treatment, but relapses were common from fresh alimentary upsets or local causes. Without unremitting care recovery, with freedom from subsequent attacks, was doubtful. The original causes generally brought out the eczema again. Great care in management was most essential. The digestive functions and action of the bowels must be regulated; diet must be watched. Plenty of water should be given and salicylates in those with a rheumatic ancestry. A half drachm twice daily of castor oil and aromatic syrup of rhubarb for one or two weeks frequently cured the eczema. Exercise and fresh air in good weather were indicated; also iron and cod-liver oil. Locally soap and water should not be used but vaseline or sweet oil. Scratching must be prevented. Locally boric acid, zinc oxide, bismuth subgallate, phenol, calamine lotion, Lassar's paste, kaolin paste, and many other applications might be employed.

Dr. Clarence K. Dengler, by invitation, showed two cases of impetigo contagiosa. Impetigo was an acute contagious auto- and hetero-inoculable skin inflammation, characterised by the formation of discrete superficial rounded or oval vesicles or blebs, which became pustules, broke down and formed yellow or brownish crusts. It was mainly in poor and unclean children. It might become epidemic from exchange of clothing, common use of towels, etc. It nearly always began in abrasions, fissures or herpes, and often complicated vaccinations, and parasitic diseases accompanied by scratching. About 75 per cent. occurred in young children. The first lesion might be a vesicle or pustule, which contained pus and blood-corpuscles, epithelial cells, and different micro-organisms. Crusts soon formed, dropped off, and the lesions healed without scar-formation. Its favourite sites were the face, scalp, and about the finger-nails. The disease might last two weeks or longer. There was very slight or no itching. Care must be taken to distinguish impetigo from pustular eczema, sycosis, ulcerating syphilides, chicken-pox, and ecthyma. The condition was readily cured by washing off the pus and dirt with soap and water after removing crusts with sweet oil, then cleansing with bichloride of mercury or carbolic acid in weak solution, and application of ammoniated mercury ointment from ten to thirty grains to the ounce.

Abstracts from Current Literature.

Medicine.

A case of enlarged thymus (*'Arch. Brasil. de Med.,'* 1911, I, *p.* 572).—**M. Leitão** records a case in a male child, aged 10 months, who had suffered since birth from continuous dyspnœa, with occasional attacks of suffocation. On crying or in the recumbent position the neck veins were markedly swollen, being less so when the child was in repose or erect. The stridor was chiefly inspiratory. A smooth, rounded tumour could be felt rising above the manubrium on inspiration, but was hardly perceptible on expiration. On percussion it yielded a triangular area of dulness with the base uppermost, and merging below with the cardiac dulness. Confirmatory evidence of an enlarged thymus was given by the X rays. Blood-pressure was a little above the normal for the child's age: maximum 85 mm., minimum 58 mm. Blood examination: Mononuclears 9·56 per cent., eosinophiles 9·5 per cent., mast-cells 1·9 per cent. Local application of X rays was made twice weekly, each sitting lasting from 45 seconds to a minute, and in two months the supra-sternal tumour could no longer be felt, the neck veins had completely disappeared, and the thymus dulness and X-ray shadow were normal. The mononuclears had now fallen to 6·2 per cent., the eosinophiles to 3·6 per cent., and the mast-cells to 0·4 per cent. Leitão concludes that X rays have a most satisfactory action in cases of enlarged thymus, and except in cases of imminent death from suffocation should always be preferred to surgical treatment. J. D. Rolleston.

Sarcoma of thymus (*'Lancet,'* 1911, II, *p.* 1253).—**W. Sheen** and **C. A. Griffiths** record cases in boys, aged 8 and 18 years respectively. In both there was an acute onset with attacks of dyspnœa, dilatation of veins of neck and thorax, swelling of lower part of neck, and dulness over manubrium. In the younger boy relief was obtained by opening the superior mediastinum, and removing fragments of the growth. Death occurred twenty-five days after the operation with signs of secondary involvement of the lungs, liver, spleen, and glands. The older patient, in whom the growth was localised, died shortly after the operation. Microscopically in each case the growths were round-celled sarcomata. J. D. Rolleston.

Tumour of the suprarenal capsule (*'Austral. Med. Journ.,'* 1911, I, *p.* 50).—**A. S. Trinca** describes the case of a boy, aged 3 years, in whom a tumour of the suprarenal capsule was removed, with recovery. There was at the time no sign of metastases. Although the prognosis was unfavourable, a microscopical examination of the growth revealed areas of tissue growth resembling an endothelioma. F. R. B. Atkinson.

Pulsating spleen (*'Med. Record,'* 1911, I, *p.* 651).—**Manges** showed at the New York Academy of Medicine a girl, aged 6 years, who had for a long time suffered from double mitral disease and a pulsating liver and enlarged spleen. The latter lately had been noticed to pulsate. This pulsation was independent, and not transmitted from the heart, liver, or aorta. The author only found seven cases in the literature, in all of which aortic regurgitation was present. F. R. B. Atkinson.

Cretinism (*'Practitioner,'* 1911, LXXXVII, *p.* 364).—**B. C. A. Leeper** divides cretins into three classes: (1) The subjects are entirely destitute of reproduction and usually cannot speak (cretins). (2) Reproductive faculties and some rudiments of speech exist, but the intelligence only goes as far as the bodily wants (semi-cretins). (3) There is a higher amount of intellect than in class 2; there is some aptitude for learning a trade and doing light work (cretinoids). Leeper finds out of thirty-three deaths in the Earlswood Asylum of cretins, eighteen were due to tuberculosis, figures which seem to show that in an institution tuberculosis is much more common in this disease than it is generally supposed to be. Liq. thyroidei ♏i–ij or gr ¼–½ of the powder every night at the onset, gradually increased by one minim every week or ten days till tolerance is established, is recommended for treatment. If the pulse becomes rapid and pains in the limbs occur, the child should be put to bed and the dose reduced.

F. R. B. Atkinson.

Obesity in children (*'Rev. d'hyg. et de méd. inf.,'* 1911, x, *p.* 241).—**Léopold Lévi** has recently observed about a dozen cases of obesity in boys, aged from nine to fifteen years, associated with genital atrophy and feminism. Symptoms of thyroid insufficiency were also present. The patients were either small and below the average height for their age, or tall with overgrown extremities. In the latter class there was possibly some pituitary over-activity. Thyro-testicular insufficiency is not sufficient to produce obesity, for some cases of infantilism due to this cause are actually lean, but over-feeding and sedentary habits are important contributory factors. The writer records two cases in which improvement followed administration of thyroid extract and reduction of diet.

J. D. Rolleston.

Inflammatory tuberculosis and blood-vascular glands (*'Ann. de Méd. et Chir. Inf.,'* 1911, XV, *p.* 465).—**A. Poncet** and **A. Lériche** consider the effect on the organism of tuberculosis of the various blood-glands, passing in review the thyroid, hypophysis, pancreas, suprarenals, ovary and testicle. The paper is interesting, but does not call for a longer review, as the authors do not add anything to what is already known. F. R. B. Atkinson.

On the intra-spinal pressure in various diseases in childhood (*'Riv. di Clin. Pediat.,'* 1911, IX, *p.* 161).—**C. Francioni** describes his manometer to measure the pressure which was taken in seventy-four cases. The estimation of the pressure of the cerebro-spinal fluid in various diseases is a distinct diagnostic help, and in some cases furnishes a material indication for the abstraction of the fluid as a therapeutical measure. The pressure in the normal infant, which amounts to 10 to 12 mm. of mercury in the lateral position, is as a rule increased in tuberculous meningitis. The same holds good for hydrocephalus; in this disease, in which the amount of pressure ought to serve as a guide to treatment, a progressive diminution in the amount of pressure indicates that there is a tendency to recovery or improvement. Pressure is increased, but to an extent on an average much more limited and irregular in meningococcic and purulent meningitis. Very high degrees of pressure are reached in all those diseases in which there is some modification of intra-cranial circulation. In the acute stage of poliomyelitis there is, as a rule, an increase of pressure, and this fact, added to others furnished by qualitative changes in the fluid, leads one to suppose

that at this stage there is an inflammatory reaction on the part of the meninges or a circulatory disturbance. In rickets there is frequently an increase of tension in the cerebro-spinal fluid, which may be explained by the toxic stasis suggested by Mya. VINCENT DICKINSON.

Meningismus from acute cervical adenitis and peritonsillar infection (*'Journ. Amer. Med. Assoc.,'* 1911, I, *p.* 1443).—**Coues** reports the case of a boy, aged 4 years, whose mother suffered from pulmonary tuberculosis when pregnant with the patient. The cervical glands became enlarged, and a few days later there was stiffness in the right side of the neck and a raised temperature. The tonsils were chronically enlarged but showed no membrane or exudate. The boy became apathetic and the glands were large and tender. Eleven days after the onset of the symptoms the breathing was stertorous and the pulse weak and irregular. The nose was obstructed, and though the throat showed nothing, antitoxin was administered. The head and neck were absolutely rigid, and Kernig's sign was present. The cervical glands were large and there was a bulging over the left tonsil. On the next day the left tonsil had subsided, but the right was affected in a similar manner. This quickly subsided and the patient improved. The rigidity of the neck passed off and the glands became smaller. The boy eventually recovered. The possibility that tuberculous meningitis was present was at one time entertained owing to the history of the boy's mother.

T. R. WHIPHAM.

New reflex signs in meningitis (*'Journ. Amer. Med. Assoc.,'* 1911, I, *p.* 114).—**Northrup** advocates Brudzinski's sign in meningitis as being "probably one of the best signs in the diagnosis of this disease, although it does not differentiate between the various forms." The sign comprises two reflex phenomena—the identical reflex and the contra-lateral reflex. The former is elicited by forcibly flexing the head on the chest when the legs are abducted and flexed and the arms are rotated externally and flexed at the elbows. The contra-lateral reflex is produced by passive flexion of one leg, which causes the opposite limb to draw up into the same position. Of the two the neck sign is the more constant. T. R. WHIPHAM.

A case of epidemic cerebro-spinal meningitis in an infant, aged 9 months (*'La Pediat.,'* 1911, XIX, *p.* 119).—**L. Consiglio** reports this case, which ended fatally, and discusses the question of diagnosis and treatment. He considers that these are cases of purulent cerebro-spinal meningitis in which it is not possible to make a diagnosis without lumbar puncture, which affords valuable information by way of enabling the epidemic form to be differentiated from others. A safe criterium is also afforded by the serum reaction, which by its simplicity is a good substitute for bacteriological investigation, which is difficult and not always possible. The discovery of Weichselbaum's meningococci is of no prognostic value. In the same subject affected with this disease we may find meningococci which differ in morphological and cultural characters; hence the various types admitted by many authors must be considered simple modifications of one and the same micro-organism, *i.e.* the meningococcus. Lumbar puncture is the only efficient method of cure in epidemic cerebro-spinal meningitis, and treatment by serum is hopeful provided it is adopted early. The specific agent is found in the respiratory passages of individuals in immediate contact with the patient without their presenting any morbid phenomena, and this explains the transmission of infection. VINCENT DICKINSON.

Meningococcus septicæmia (*'Journ. Amer. Med. Assoc.,'* 1911, I, *p.* 1446).—**Skilton** saw a boy, aged 12 years, who first complained of pain over the mastoid region on both sides with swelling and tenderness. Temperature, 104° F.; pulse, 100. There was no headache or vomiting, but slight ptosis of the left eyelid and some rigidity in the neck and extremities. On lumbar puncture 25 c.c. of turbid fluid escaped under pressure; meningococci were found in it, both free and within polymorphonuclear leucocytes. The leucocyte count was 7500, 85 per cent. of which were polymorphonuclears. Many of these contained diplococci, which were found in the mononuclear cells as well. Extra-cellular organisms were not seen. The result of the case is not stated. T. R. Whipham.

Meningococcic meningitis treated with Flexner's serum (*'New York State Journ. of Med.,'* 1911, XI, *p.* 493).—**Springarn** relates the case of an infant, aged 3 months, in which, after removing 20 c.c. of cerebro-spinal fluid (which had shown a large number of meningococci and 100 per cent. of polynuclear leucocytes), he injected into the subarachnoid space a like amount of anti-meningitis serum. After the injection the infant appeared to be in a state of collapse, but soon rallied and was better. On the following day 30 c.c. of cerebro-spinal fluid were withdrawn and the same amount of anti-meningitis serum was injected. The injections were repeated on five more days in succession, 20 c.c. of serum being introduced each day: on the three last days no cerebro-spinal fluid was obtained on lumbar puncture. During this time the condition of the child gradually improved, the whining ceased, the eyes lost their peculiar stare, the pupils reacted normally to light, the rigidity of the neck and limbs disappeared, the reflexes became normal, and the temperature showed no elevation at the end of eight days following the first injection. Altogether 150 c c. of serum were used, being introduced into the subarachnoid space, not by means of a syringe, but by gravity, the serum flowing in from an upright glass tube attached at its lower end to the rubber tubing connected with the lumbar needle; the serum was slightly warmed before being used. The infant was watched for three weeks following the disappearance of the meningitic symptoms and no tendency to relapse was noted. Of twenty-two cases collected by Flexner and Jobling of infants under one year treated with the anti-meningitis serum, one half were fatal, and only two or three cases occurred in infants less than four months of age. J. E. Bullock.

Paratyphoid meningitis (*'Jahrb. f. Kinderheilk.,'* 1911, LXXIV, *p.* 462).—**Gorter** reports a case in a child, aged 8 months. A pure culture of the paratyphoid bacillus was obtained from the cerebro-spinal fluid. Agglutination with paratyphoid *B.* serum 1 in 3000 positive; after lumbar puncture the meningeal symptoms disappeared, and the child presented the typical symptoms of tetany. Death from inanition. No necropsy (*cf.* British Journal of Children's Diseases, 1910, VII, *p.* 513).

J. D. Rolleston.

Recovery from tuberculous meningitis (*'Jahrb. f. Kinderheilk.,'* 1911, LXXIV, *p.* 155).—**W. G. Archangelsky**.—A girl, aged 8 years, whose brother had died three days previously of tuberculous meningitis, was admitted to hospital with symptoms of tuberculous meningitis on the eighth day of disease. Lumbar puncture, performed on admission, gave issue to a clear fluid, containing numerous mononuclears and tubercle bacilli. The fluid

from the second puncture on the twenty-third day contained fewer mononuclears and no tubercle bacilli. On the twenty-ninth day the fluid was almost normal. Right facial palsy developed on the twenty-third day, and persisted till the hundredth. Complete recovery took place, and when seen two years later the child had shown no cerebral symptoms since the illness, and her intellect was good. About fifty cases of recovery from tuberculous meningitis are on record, but in many the diagnosis was doubtful, and lacked bacteriological and biological confirmation. In only four cases besides the present one were tubercle bacilli found in the cerebro-spinal fluid; in a fifth injection of the fluid into a guinea-pig produced miliary tuberculosis, though no bacilli had been found in the fluid.

J. D. Rolleston.

Surgery.

Cystic ovary in the fœtus (*'Journ. de Méd. de Bordeaux,'* 1910, xl, *p.* 805).—**Lafond** describes what he considers a unique case in a fœtus born at term. Both ovaries were transformed into polycystic masses as large as big almonds. The individual cysts varied up to the size of a large pea; they were lined with three or four layers of stratified epithelium, and enclosed granular or mucous material. The tissue between the cysts was a fibrocellular tissue with Pflüger's tubes in process of formation. It was evidently congenital cystic degeneration. J. Porter Parkinson.

Hypertrophy of the breast at puberty (*'Arch. de méd. des enf.,'* 1911, xiv, *p.* 172).—**H. Caubet,** from his observations on one case of his own and from the published records of other authentic cases, believes that heredity has a marked influence on the occurrence of the disease, and that amenorrhœa is not a cause, but a result. The case that he records is of especial interest as the child's mother suffered from the same ailment, and was cured by amputation of both breasts. Rupert Farrant.

Rupture of the spleen (*'Indian Med. Gaz.,'* 1911, xlvi, *p.* 136).—**W. J. Niblock** describes a case in a Hindu girl, aged 6 years, who was run over by a bullock cart. The patient showed all the signs of internal hæmorrhage, and on operation the spleen was found torn into several pieces. The whole organ was removed and the child made a complete recovery.

F. R. B. Atkinson.

The ligaments in health and disease (*'Rev. d'hyg. et de méd. inf.,'* 1910, ix, *p.* 472.)—**Ducroquet.**—Ligaments when relaxed contract, when stretched they lengthen. It is owing to these two main facts that many deformities are produced. The ligaments by themselves are unable to maintain a joint in its normal position. The true ligaments are the tendons and the muscles. When a muscle or group of muscles are paralysed or in a state of hypotonus, the whole strain is cast on the ligaments, and thus orthopædic conditions are produced. The main idea of treatment of many of these conditions, such as club foot, flat foot, genu valgum, etc., depends on utilising these functions of ligaments, namely, relaxing the lengthened and stretching the contracted. A warning is given that whilst treating one deformity another may be produced from ignoring these functions, notably in Little's disease and in hip disease. During the application of a plaster the leg is apt to be supported only by the heel, causing the flexors of the knee to be tired out and stretching of the posterior ligament; if a series of plasters be applied in this way, a genu recurvatum is bound to occur. Rupert Farrant.

The treatment of congenital talipes equino-varus in the new-born (*'Journ. de Méd. de Paris,'* 1911, xxxi, *p.* 535).—**R. Sainton** recommends the early application of a poroplastic splint, the foot being placed in a position of complete extension and the varus unrolled as far as possible. This splint should be taken off daily and the foot massaged. A fresh splint should be fitted at the end of six weeks with the foot still in a position of complete extension and the varus now over-corrected; this must be worn for eight weeks. Then, and then only, the equinus may be corrected by tenotomising the tendo Achillis and a gutta-percha boot made. A long course of massage is still required to effect a permanent cure.

Rupert Farrant.

Simple and complete reduction of deformity in fixed lateral curvature of the spine (*'New York Med. Journ.,'* 1911, i, *p.* 1217).—**E. G. Abbott** regards all cases of scoliosis, except those due to definite disease of the bone, as being capable of complete cure in a comparatively short time by the application of plaster jackets, even though there be alteration in the shape of the vertebræ and contraction of muscles and ligaments. He bases his ideas on the deformity produced on a normal spine by fixing it in a position of scoliosis for a month in a plaster jacket, and then curing the curve obtained by fixing it for another month in an over-corrected position. The article is illustrated with photographs, diagrams, and X-ray pictures of cases he has treated in this way.

Rupert Farrant.

Diagnosis of congenital dislocation of the hip in the infant (*'Gaz. Heb. des Sci. Méd. de Bordeaux,'* 1910, xxxi, *p.* 531).—**Villeon.**—The diagnosis of this condition is of great importance, as the earlier it is treated the better the result. The sign of "exaggerated internal rotation" is the most reliable sign. The principle is that excessive internal rotation of the femur can only take place when there is congenital dislocation of the hip-joint. Excessive laxity of the articulation and torsion of the femur on its axis have to be eliminated. The best method is to lay the infant on one side, flex the opposite thigh, bend the knee and rotate the femur by bringing the foot upwards; it will be found that on the sound side the leg can only be brought to an angle of about 45° with the table, while on the side of the dislocation the leg can be brought almost to the vertical position. The author states that this sign is pathognomonic.

J. Porter Parkinson.

Surgical treatment of Little's disease (*'Norsk Mag. f. Læg.,'* 1911, lxxii, *p.* 979).—**A. Cappelen.**—A child, aged 8 years, who had never been able to walk, raise itself or stand, had the second, third, and fifth lumbar, and first sacral sensory roots divided. Numerous contractures were also rectified by tenotomy. After eight months' treatment the patient could get up, stand, and walk with support.

J. D. Rolleston.

Dry caries of shoulder-joint in a child, aged 9 years, successfully treated (*'Journ. de Méd. de Bordeaux,'* 1911, xli, *p.* 613).—**L. Rocher** relates the case of a child who, four years after an injury to the shoulder, presented herself for treatment for dry caries of the joint. The shoulder-joint was opened and the synovial membrane with its prolongations removed, and the affected bone curetted. The cavity was dried with tampons soaked

in oxygenised water, and then filled with the mixture suggested by Mosetig-Moorhof. It was then closed, and the part immobilised by the dressings. It was healed in three weeks and the plaster removed at the end of two months, when the disease seemed permanently cured.

J. Porter Parkinson.

Tuberculous hip (*'Practitioner,'* 1910, i, *p.* 142).—**Stonham,** in the early stages, rectifies any deformity that may be present by weight extension such as the child can bear without inconvenience or pain. When, after perhaps a week or ten days, the limbs are parallel, he puts on a Thomas splint, using a double splint for quite young children who cannot get about on the sound limb with crutches. He generally makes children who have had undoubted evidence of hip disease wear the splint for a year, *i. e.* he continues it so long as the child is improving, but directly there is indication of suppuration taking place in the joint, and there is increasing pain on slight movement, a splint is of no use, and surgical procedure is necessary.

J. E. Bullock.

Tuberculous disease of knee (*'Practitioner,'* 1910, i, *p.* 332).—**Watson** expresses the following conclusions: Mixed infection spells doom to the joint. There are two knees worth having—the movable, when it is stable, and the fixed, when it is straight. Erasions seldom produce either. Fibrous ankylosis spells flexion and failure. The tubercle bacillus sometimes wrecks a child's joint, but erasion and excision are worse offenders. In the young adult excision is very good. J. E. Bullock.

Results of treatment of white swelling of the knee by injections of chloride of zinc (*'Gaz. Heb. des Sci. Méd. de Bordeaux,'* 1911, xxxii, *p.* 75).—**A. Charrier** relates two cases treated successfully by this method. They remained well for seven and nine years respectively, when swelling and pain returned. They were again treated by injection of a drop of one tenth solution of chloride of zinc; this was injected deeply into the periosteum at the edge of the swelling. Eight drops were injected at intervals of one centimetre from each other. The subsequent pain was relieved by morphia. A fortnight later this was repeated, and so on for five months, when the disease was completely cured. The joint was of course completely ankylosed.

J. Porter Parkinson.

On para-articular osteotomy in ankylosis of the tuberculous knee-joint (*'Prag. med. Woch.,'* 1911, xxxvi, *p.* 237).—**G. Eckstein** claims that this operation leaves the joint in its fixed bent position in complete rest, whilst it avoids the seat of the disease. Simple replacement of the joint in the straight position is fraught with danger; arthrectomy and resection invariably give bad results sooner or later. Before the operation of osteotomy is undertaken some two years must have elapsed since symptoms of disease were present—pain, abscesses, fistula, fever, must all have disappeared. Through a Röntgen rays examination the condition of the joint is ascertained. The object of the operation is to lengthen the limbs so that the patient can stand straight on the sole, with or without a shoe, but without support, avoiding the danger of any local recurrence of the disease or a recontraction. The operation being carried out in healthy bone and tissues is without danger; healing lasts only a few weeks. The ligaments of the ham are divided subcutaneously, care being taken of the peroneal nerve. Osteotomy

is then performed as close as possible to the condyles; in growing persons the epiphyses must be avoided. When the contraction is 130° this osteotomy is sufficient. If it is 90° a second osteotomy of the tibia must be carried out, just at the condyle. This is better done some weeks later. Adduction and rotation of the leg can be corrected at the same time, whilst the thigh or leg can be lengthened at the same time if necessary, as Schanz and Werndorff have demonstrated. Illustrations of three patients before and subsequent to operation are given. M. D. Eder.

Tubercular peritonitis with intestinal fistulæ (*'Liverpool Med.-Chir. Journ.,'* 1911, xxxi, *p.* 389).—**G. P. Newbolt** reports the case of a child, now aged 12 years, who first came under his care when four years old with two large fæcal fistulæ, as the result of tubercular peritonitis, through which the whole of the intestinal contents passed. Plastic operations were tried and failed. Short circuiting was done with a satisfactory result; prolapse of bowel occurred and portions were excised; muco-pus collected in shut-off coils which required to be opened, drained, and later excised. In spite of the fact that adhesions from this disease or from subsequent operations have practically obliterated his peritoneal cavity, his fistulæ are closed, he remains in good health and attends school, his bowels acting in the ordinary way. In all some twenty operations have been performed, including the removal of a stone from his bladder.

Duncan C. L. Fitzwilliams.

Treatment.

Treatment of rickets by drugs and other remedies (*'Paris Méd.,'* 1911, i, *p.* 383).—**A. B. Marfan,** in a preceding article, has considered the treatment of rickets by hygiene, hydrotherapy, and diet, and now goes on to discuss in detail the drugs and other measures employed for its cure. The chief drugs are cod-liver oil and preparations of phosphorus and calcium. Yellow oil is to be preferred in doses of two teaspoonfuls *per diem*, gradually increased to tablespoonfuls. Under the age of two it is generally not tolerated. The preparations of phosphate of lime are various, and seem to act as tonics to nutrition and stimulants of the nervous system. The preparations of phosphate of calcium have the disadvantage that they are insoluble and have been recommended to be taken as a powder in the food, Simon considering that they are rendered soluble by the gastric juice transforming them into the chloro-hydrophosphate. The soluble phosphates in common use are the syrup of lacto-phosphate or the chloro-hydrophosphate of lime of the codex, in doses of from one to three teaspoonfuls a day. The author finds the hypophosphite of lime (0·10–0·20 gr. *per diem*) more efficacious. Others have found a solution of tribasic-phosphate, alkaline citrates, and sugar of milk beneficial. The author particularly recommends glycerophosphate of lime in doses of 0·05 to 0·20 gr. according to age; larger doses seemed to produce nervous excitement. Kassowitz is a great believer in oil of phosphorus given as follows: Phosphorus, 1 cntgr.; cod-liver oil, 100 grm.—one to three teaspoonfuls a day. Others find oil of bitter almonds a better vehicle, and the author recommends this vehicle in preference to ol. morrhuæ. Some deny any therapeutic value to phosphorus in the treatment of rickets and proscribe it altogether, but Marfan finds that it acts beneficially on the general state of health and on the nervous system, but its action on bone seems to be doubtful save in craniotabes of young

children, when it appears to cause a quicker consolidation. Others recommend organic compounds of phosphorus from the tissues of animals or vegetables, as lecithin, nucleinate of soda, phytine, but Marfan has not had sufficient experience of them to form an opinion of their value or otherwise. Having been impressed by the value of the glycero-phosphate of lime he endeavoured to find out whether its efficacy was due to the phosphorus or the lime, and prescribed in some cases chloride of calcium, lactate of calcium, and formiate of calcium. The two former he discarded, and after many trials found the following combination most beneficial: Syrup of lemon 150 grm., glycero-phosphate of lime (liquid) and formiate of lime āā 2 grm. One to four teaspoonfuls *per diem* according to age. Hydrochloride of ammonia and chloride of sodium have also been found useful. The former should be given in doses of 0·10 to 0·20 gr. *per diem* with bicarbonate of soda divided into four doses and discontinued for a few days after eight days. A small pinch of the latter should be added to each bottle of milk, and if the child is at the breast added to the mother's diet. Organotherapy has also been tried in rickets with varying results. The following have been recommended: Bone-marrow, extract of periosteum, and fundamental substance of the bone (results not detailed); thyroid (no obvious result save when rickets has been associated with hypothyroidism, in which case it has acted beneficially); thymus (valueless); adrenalin. The author recommends an extended trial to the latter in solution of $\frac{1}{1000}$ (one to six drops *per diem*) by the mouth, but not hypodermically: parathyroid gland (no result). Galvanisation of the spine by alternate currents, and hydro-electric baths and electric light (35°–40° F.) for fifteen minutes, followed by a cold douche of ten seconds, have been found useful. The treatment of the deformities depends on the stage of the rickets. In the first stage, before consolidation of the bone has taken place, padded splints, accurately applied, should be used. In cases of genu valgum with slight valgus a laced boot should be worn on walking, the sole raised on the inner side. General and respiratory gymnastics should be employed to remove the thoracic deformity, and lateral suspension on the mother's knee, and appropriate corsets the scoliosis. After the fourth year the deformities, save those of the chest, are usually final. The same remedies as just mentioned should be continued to remove the thoracic deformity, but malformation of the limbs will almost certainly require surgical intervention. In late rickets treatment by gymnastics, orthopædics, and surgical intervention play a greater part than in rickets of early infancy. F. R. B. Atkinson.

The treatment of "summer diarrhœa" (*'Guy's Hosp. Gaz.,'* 1911, xxv, *p.* 356).—**H. C. Mann,** in some notes on the treatment of "summer diarrhœa," states that he is opposed to the "starvation treatment" of this malady. He recommends feeding throughout the illness on undiluted citrated milk. This view he supports by a series of figures obtained by analysing the amount of fat excreted in the fæces of three severe cases in which the intake of fat was also reckoned. He found that while administering in the diet from 19 to 23 grm. of fat in twenty-four hours, only from 4 to 7 grm. of fat were voided during the same period, leading to the conclusion that a good deal of intestinal digestion is possible during this disease. Reginald Miller.

"Fixation abscess" in the treatment of broncho-pneumonia in infants (*'Lyon méd.,'* 1910, cxv, *p.* 925).—**Montagnon** takes exception to

the statement of Campana and Codet-Boisse that turpentine injections for this purpose are dangerous in children under five years of age, and publishes the results of twenty-six cases, the ages of the subjects varying from four months to five years. Six cases are given in detail with temperature charts. The first question is that of dosage. The use of 1 c.c. even in children of four to five years may be attended with troublesome skin complications. The personal experience of the author is that by using $\frac{1}{3}$ c.c. turpentine up to the age of twelve months, and $\frac{1}{2}$ c.c. from one to five years, the dose may be repeated if requisite but never requires increasing. He always practises the injection in the lateral part of the anterior abdominal region about the level of the hypochondrium, on a horizontal line three fingers' breadth from the umbilicus. This region is preferred, as the infant is not prevented lying on its back, the resulting abscess not being painful. The inflammatory reaction is apparent next day and very evident at the end of forty-eight hours. About the sixth or seventh day the pus is evacuated; cicatrisation is complete on the fifteenth. Turpentine injection has not only a therapeutic action but also a diagnostic and prognostic importance. If suppuration is not caused it means that the organism can no longer react, that the phagocytic power is exhausted and the prognosis grave; it is the same when the temperature does not come down during the following two or three days. On three occasions out of four when this happened tuberculosis was verified on autopsy. These facts are not numerous enough for an absolute conclusion to be drawn, but the coincidence is interesting, and may throw light on a number of cases where the clinician hesitates to pronounce on the nature of the affection. To obtain the best results the use of the injection should be avoided at the onset of the attack. If in spite of mustard baths and oxygen inhalations the temperature remains high, if the dyspnœa does not yield about the third or fourth day, then the best results may be obtained from turpentine injections. At the beginning of an infection the defence of the organism is at its height, and to seek to increase it would be, to say the least, useless; if, on the other hand, the turpentine injection acts as a stimulus to phagocytosis, it is when this is declining that the fixation abscess is able to give it a fresh impulse. VINCENT DICKINSON.

Treatment of tuberculous peritonitis (*'Monde Médical,'* 1910, xx, *p.* 289).—**Robin** relates two cases illustrating the treatment of this condition. (1) A girl, aged 15 years, showed a considerable amount of ascites, not encysted; there was no evidence of pulmonary lesion, and the other organs appear to be healthy. (2) A man, aged 40 years, a confirmed alcoholic; his abdomen gave signs of encysted ascites, and there was distinct evidence of tuberculosis in both lungs with pleurisy. The girl was treated with fresh air, rest, and suitable food; she improved, but the ascites continued, and required to be reduced by puncture followed by washing out with boracic acid water. After a second puncture she improved so much that she was discharged, two months after admission to the hospital, apparently in the best of health. In the case of the man, laparotomy or puncture was not entertained on account of the pleuro-pulmonary lesions and the encysted collection of fluid, together with fibro-caseous lesions in the abdomen; he was discharged after improvement under general medical and hygienic treatment, but there was every reason to expect a recrudescence of his disease.

J. E. BULLOCK.

Treatment of tuberculous glands (*'Practitioner,'* 1910, i, *p.* 741).—**Bennett** points out that in the primary adenitis the focus of infection must

be sought and treated; if no focus can be found, removal of the glands is strongly indicated. If the primary source of infection has been cured or become non-existent, and yet the affected gland does not diminish, it is very suggestive of invasion by tubercle. He recommends tuberculin treatment only in the early stages of invasion, and calls attention to the value of X-ray examination (tuberculous deposit in glands, especially if caseation is in progress, is resistant to X rays, and is not likely to be amenable to tuberculin). Under climate he advises sea air rather than high altitudes: Children born at and living at the seaside who develop tuberculosis there benefit by a change inland, while those who develop tuberculosis inland benefit by a change to the sea, hygienic conditions being equal. He has noticed that a return to the child's native place has brought about remarkable benefit when other treatment has failed. The less a tuberculous gland is worried by local applications the better. In the event of suppuration he recommends operation: in the case of deep glands before the broken-down contents escape from the capsule into the deep fascia; in the case of superficial glands before the skin becomes involved in the inflammatory process. Should the capsule have given way, scraping with a sharp spud will be necessary to remove all diseased tissue. In the case of subfascial glands there is often a small opening in the deep fascia, which leads into the centre of a diseased gland; this must be cleared out or permanent healing cannot result. A persistent sinus after operation is due to the disease having been inadequately removed, or to infection of the operation area by some micro-organism other than the tubercle bacillus; it must be treated by an appropriate vaccine.

J. E. Bullock.

Purpura hæmorrhagica successfully treated with human blood-serum (*'Med. Record,'* 1910, II, *p.* 930).—**C. G. Kerley** reports a case of severe purpura in a non-hæmophilic boy, aged 5 years. Various hæmorrhages occurred over a period of three weeks, the most serious of which were repeated and prolonged attacks of epistaxis from which the child was rendered *in extremis*. At this point, within one day, 290 c.c. of human blood-serum were injected hypodermically and large quantities were given during the next week. The hæmorrhage ceased within fifteen hours of the first injection, and it appeared to the author that this treatment was directly responsible for saving the child's life. Reginald Miller.

Treatment of chorea by injections of sulphate of magnesia into the spinal meninges (*'Gaz. Hebd. des Sci. Méd. de Bordeaux,'* 1911, XXXII, *p.* 409).—**Rocaz** records five cases of chorea treated in this way. It is known that salts of magnesium inhibit conduction of impulses down the nerves, and it has been used as a treatment of severe neuralgias. The solution used is of a strength of 25 per cent. in sterilised water. Twelve c.c. of cerebro-spinal fluid being withdrawn, 2 c.c. of the solution is injected. After the injection the temperature falls below normal, the pulse becomes slow, and there is pallor of the face and prostration, occasionally vomiting and incontinence of urine and fæces. An hour later the legs are paralysed and the choreic movements disappear. After injection of caffeine the child improves from the prostration, and the pulse rises and the temperature becomes slightly elevated. The next day the child is apparently well, with no choreic movements. Sometimes a second injection is necessary and may be done five or six days after the first.

Four cases so treated were absolutely and rapidly cured; the inconveniences of the treatment are that there is frequent headache and pains in the limbs; these, however, may be lessened by an injection of morphine. The other troubles, such as vomiting, deep and sometimes rapid respiration, paralyses, etc., disappear after a few hours, and are more alarming than dangerous.

J. Porter Parkinson.

Correspondence.

TRANSMISSION OF DISEASE BY MEANS OF BOOKS.

To the Editor of The British Journal of Children's Diseases.

Dear Sir,—I am engaged in collecting data, part of which is to be used in a paper to be read before the next International Congress of Hygiene, and in order to obtain data, respectfully request the readers of this note to send me an account of any cases the source of which has been traced to books or papers, or where the evidence seemed to make books or papers the offender. I would also further request information where illness or even death has been caused by the poisons used in book-making.

All the information possible is wanted to present as complete a paper as possible. As in the case of insects, which we now know to be "carriers of disease," it is first necessary to collect the scattered evidence in order to show that there is real danger in books; and this will compel better care to be taken of libraries and books and improve the health of mankind.

Thanking you in advance,

I am, very truly yours,

1709, Wallace Street,
Philadelphia, Pa.;
October 25, 1911.

Wm. R. Reinick,
Chief of the Free Library, Philadelphia.

DISEASE IN HOMOGENEOUS TWINS.

To the Editor of The British Journal of Children's Diseases.

Dear Sir,—I was much interested in Dr. Cockayne's paper, in the last number of the Journal, on "Disease in Homogeneous Twins." I remember some years ago seeing in consultation a little girl in a very severe attack of cyclical vomiting. I was told that her twin sister had died in a similar attack not long before, and that both children used to be subject to attacks simultaneously, even although they did not happen to be living at the same place at the time. I am sorry that I cannot furnish any further details of the case, but owing to the rarity of these conditions in homogeneous twins I thought it might be worth mentioning, as perhaps your readers may be able to provide other examples.

Yours sincerely,

22, Queen Anne Street,
Cavendish Square, W.
November 18, 1911.

Robt. Hutchison.

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